Supreme Court, U. S.
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No. 74-1274

In the Supreme Court

of the United States

OCTOBER TERM, 1975

ABBOTT LABORATORIES, an Illinois corporation; AMERICAN HOME PRODUCTS CORPORATION, a Delaware corporation; BRISTOL-MYERS COMPANY, a Delaware corporation; CARTER-WALLACE, INC., a Delaware corporation; ELI LILLY AND COMPANY, an Indiana corporation; ENDO LABORATORIES, INC., a Delaware corporation; ORTHO PHARMACEUTICAL CORPORATION, a New Jersey corporation; SQUIBB CORPORATION, a Delaware corporation; E. R. SQUIBB & SONS, INC., a Delaware corporation; A. H. ROBINS COMPANY, INC., a Virginia corporation; WILLIAM H. RORER, INC., a Pennsylvania corporation; and WARNER-LAMBERT PHARMACEUTICAL COMPANY, a Delaware corporation,

Petitioners,

v.

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC., an Oregon non-profit corporation, on behalf of its assignors,

Respondent.

PETITIONERS' REPLY BRIEF

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ABBOTT LABORATORIES, an Illinois corporation, et al.,

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v.

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC., an Oregon non-profit corporation, on behalf of its assignors,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

PETITIONERS' REPLY BRIEF

INTRODUCTION

In view of the narrow question before the Court, respondent's broadside attack upon the pharmaceutical industry (Resp. Br. 5-7, 12-16) is unjustified and irrelevant. The hospitals, not petitioners, decide how their drug inventories shall be used, and the only question to be decided is whether the hospitals' purchases of drugs are for their "own use". The price

differences which concern respondent reflect policies that have been in effect for many decades and were given legislative sanction in the Nonprofit Institutions Act. The proper forum for respondent's free-ranging discussion is the Congress, not this Court.

Two other preliminary comments on respondent's brief are appropriate. Respondent's statistical representations (Resp. Br. 19, 24-25) are derived principally from evidence relating to drug dispensing by Bess Kaiser Hospital, which, we have noted elsewhere (Pet. Br. 6, fn. 3), is affiliated with a health maintenance organization that primarily serves its own members.[1] The Court of Appeals concluded that the application of Section 13c to Bess Kaiser's drug purchases could not be determined from the record, and it ordered further discovery without adjudicating that issue (App. 308-309). None of the parties sought review of that aspect of the Court of Appeals' decision. Consequently, the application of Section 13c to drug purchases of this HMO-affiliated hospital is not before the Court, and respondent's use of the Kaiser statistics is improper.[2]

A second and more serious aspect of respondent's brief is its reliance on material that is not in the record and its erroneous statements about material that

[1] Ninety-nine percent of Kaiser's drug distribution is to its own members; its "indiscriminate" sales to the public (Resp. Br. 30) amount to one walk-in prescription per day at each pharmacy (Pirtle Dep. Ex. 2).

[2] Nor are respondent's references to the depositions of Pirtle (fns. 10, 13, 37, 39, 58) and Greenlick (fn. 41) relevant to the issue before the Court. These witnesses are Kaiser officials who testified about Kaiser operations in Portland.

is in the record. Petitioners take particular exception to respondent's extensive misuse of 1967 testimony before a congressional subcommittee, as if it were evidence in the record of this case. Some of these matters are referred to in the discussion that follows, and others are noted in the exhibit to this brief, at p. 15 below.

I.

Respondent Had Full Discovery With Respect to the Section 13c Exemption, and the Record Was Sufficient to Decide Petitioners' Motion for Partial Summary Judgment.

From the time it was first filed as a class action, this was a complex case involving a multitude of Robinson-Patman Act and other antitrust claims,[3] and the district court properly proceeded with a "method and schedule" for resolving preliminary legal questions. *Manual for Complex Litigation*, Par. 1.80. The court first considered and finally dismissed charges of discrimination in government sales. Discovery then proceeded on the Section 13c exemption question as a segregated issue (see Pet. Br. 4; Tr. 9/11/72 at pp. 29-30, 117-124). Respondent conducted broad and extensive discovery of the nonprofit hospitals' drug dispensing practices (see Tr. 11/27/72 at pp. 3-15). It deposed (and in some instances redeposed) more than 40 hospital pharmacists and administrators and other witnesses; it subpoenaed all of the hospitals' records

[3] By taking assignments from some 60 assignors of their respective claims against 11 defendants, plaintiff sought to litigate literally hundreds of Robinson-Patman and Sherman Act claims in this single action.

relating to drug distribution; and it filed 17 documents, entitled "Rule 56 Affidavits", totalling more than 300 pages, and 13 other affidavits, statements and exhibits. As a result, both the district court and the Court of Appeals accepted the record as sufficient to determine the application of the exemption to drug purchases by the 13 nonprofit hospitals in Portland.

The fact is that respondent had substantially all of the discovery it sought — and certainly all it needed—on the issue of the Section 13c exemption. Indeed, respondent has admitted this. In its brief in this Court opposing American Hospital Association's motion for leave to file an *amicus* brief supporting the petition for certiorari, respondent asserted that AHA's presentation could not help the Court, because AHA assumed the record was incomplete "when, in fact, the record was extensive, i.e., some 50 depositions and thousands of pages of exhibits, and *more than adequate for the issues decided*" (Resp. Obj. 2; emphasis added).

The district court did not abuse its discretion in considering and ruling on petitioners' motion for summary judgment. *First Nat. Bank* v. *Cities Service Co.*, (1968) 391 U.S. 253, 299.

II.

Respondent's Brief Misconceives the Issues and the Positions of the Parties.

Respondent's brief displays basic misconceptions about the issues raised by the record and the positions of the parties toward them. As a result, those matters must be clarified.

1. Petitioners have not "shifted their position", nor have they "accepted" the Court of Appeals' decision excluding various categories of drug use by the Portland area hospitals.

Respondent's contention that petitioners have "accepted" the Court of Appeals' decision as to marginal categories of drug dispensing is incorrect (Resp. Br. 3-4, 59, 66).

The question to be decided is whether the Court of Appeals erred in limiting the Section 13c exemption to inpatient and emergency room use and excluding other drug uses, principally take-home drugs and drugs dispensed to outpatients and to staff and employees for personal and family use (App. 311-312). The first two of these are a direct service to registered hospital patients, and the third strengthens and assists the hospital's internal administration (Pet. Br. 3, 10-12; Tables 2-4 at Pet. Br. 32-34).

As noted in petitioners' opening brief, other uses of drugs by nonprofit hospitals referred to by the Court of Appeals occur infrequently, if at all, and not in significant amounts (Pet. Br. 7, 12; Tables 5-6 at Pet. Br. 35-36). However, petitioners have not "accepted" the Court of Appeals' decision as to such uses. Occasional sales of drugs to nonpatient members of the public ("walk-in" customers), usually at night or on weekends or in other emergencies, or in similar circumstances to doctors and other hospitals, have no commercial significance and are a necessary accommodation to the community's medical needs. These uses,

while peripheral, constitute hospital use of drugs within the meaning of Section 13c.

2. Nonprofit hospitals are not operating retail drugstores, and there is no issue as to the application of Section 13c to a hospital pharmacy operation that "cannot be distinguished" from a commercial drugstore.

Respondent states that its dominant concern is with the hospital that acquires drugs at reduced prices and ". . . *chooses not to use them for a hospital purpose, but decides to conduct an operation which cannot be distinguished — save for location — from that conducted by a drug store pharmacy.* . . . (Resp. Br. 35; emphasis in the original). This central proposition ignores the record facts. As we have stated before, these nonprofit hospitals do not operate general retail drugstores. In fact, the record shows that they discourage or even refuse to make sales that are not directly related to the functioning of the hospital (see Pet. Br. 8-12, 31-36). There is no evidence, despite the fears of APhA (APhA Br. 5-6), that nonprofit hospitals can or do engage in general retail operations with supplies purchased under the Section 13c exemption.

We recognize and agree that purchases of supplies under Section 13c should promote hospital operations and services. All of the uses now under consideration meet that standard and are within the scope of the exemption.

3. The contention that drug distribution by nonprofit hospitals has caused competitive injury to community pharmacies is not before the Court and is not supported by the record.

The question before the Court is limited to the proper interpretation of Section 13c. Respondent's claim that hospital drug distribution has caused competitive injury to retail pharmacies, which would be necessary to a *prima facie* showing of a violation of the Robinson-Patman Act, is not before the Court (see pp. 9-10 below) and was not considered by the district court or the Court of Appeals.

Furthermore, the record does not support the contention of respondent (Resp. Br. 18-25) and APhA (APhA Br. 13-18) that hospital drug distribution has injured retail pharmacies. There is no discernible basis in the record for the contention that "In Portland more than half the drug stores have closed within the past ten years" (Resp. Br. 23). Exhibits to the deposition of A. G. McLain, Secretary of the Oregon State Board of Pharmacy, summarizing the records of the Board for the period from 1965 to 1972, show that the total number of community pharmacies in the entire tri-county area declined by just 33 during that period, from 180 to 147 (McLain Dep. Ex. 2).[4]

Nor do the maps attached to respondent's brief support the assertion that "the locations most acutely affected are those closest to the hospitals" (Resp. Br.

[4] The Oregon State Board of Pharmacy defines a "community pharmacy" as "a licensed pharmacy independently owned and operated". It is one of seven different classes of pharmacies regulated by the Board (McLain Dep. Ex. 2).

24).[5] On the contrary, they show that 33 closures occurred in the downtown core area of Portland, where there are no nonprofit hospitals.

It is scarcely credible that a minor portion of the drug sales of Portland nonprofit hospitals is responsible for the decline in the number of community pharmacies in the tri-county area. It is more probable that the retail drug business, like other businesses, has merely shifted to larger stores in suburban areas. This is suggested by Appendix I (p. 1a) of APhA's *amicus* brief, which shows that from 1962 to 1973 there was a 14 percent net decline nationally in the number of "community pharmacies," but that in 1970 this declining number of pharmacies filled 52.5 percent *more* prescriptions than in 1962. Thus, while the number of community pharmacies was declining, their total volume of prescription drug sales was sharply increasing.[6]

While not essential to the Court's decision, there is no basis in the record for contending that there has

[5] The three unidentified maps attached to respondent's brief are something of a mystery: Maps similar to two of them were received as exhibits to an affidavit of Mr. Howard Steinbach, one of plaintiff's assignors (App. 153-154; R. 541-542, 866-867). The "spheres of influence" shown on one of those maps and also on the third one attached to the brief apparently represent Mr. Steinbach's — or somebody's — opinion of the geographic effect of hospital sales.

[6] Figures in the same APhA appendix showing that the number of hospital outpatient prescriptions also increased during the same period do not distinguish between prescriptions filled by nonprofit hospitals which qualify for the Section 13c exemption and prescriptions filled by proprietary hospitals which do not, or by government hospitals whose purchases are not subject to the Robinson-Patman Act.

been a decline of the corner drugstore as the result of drug distribution by nonprofit hospitals having the benefit of Section 13c.

III.

All Hospital Drugs that Are Dispensed in the Course of Providing the Institution's Health Care Services to the Community Are Within the Section 13c Exemption; the Narrow Locational Test of Hospital Use Proposed by Respondent is an Incorrect Construction of the Nonprofit Institutions Act.

1. The Section 13c exemption applies to all supplies used by a nonprofit hospital, even if such use may involve competition with retail drugstores.

The Section 13c exemption from the Robinson-Patman Act is absolute, and it applies to all uses of drugs by nonprofit hospitals, whether or not they might be regarded as competitive with the business of commercial drugstores. In passing the Nonprofit Institutions Act of 1938, Congress favored certain activities over others. The exemption was a considered determination of social and economic policy that nonprofit hospitals and similar institutions should be permitted to purchase their supplies at favorable prices, whether or not such purchases might result in detriment to others. The possibility that this may cause a loss of sales to other economic entities is not only contemplated by Section 13c, but is inherent in its exemption, since the Section 13(a) prohibition against discriminatory sales applies only where there is a possibility of competition.

Section 13c exempts from the Robinson-Patman Act

purchases by nonprofit hospitals of supplies for their "own use", which includes all supplies used in carrying on the institutions' functions. The Court of Appeals correctly held that all of the disputed drug dispensing activities of these hospitals are proper hospital functions. It follows that hospital purchases of drugs for those purposes are within the scope of Section 13c, whether or not retail druggists could supply some part of them.

This analysis of Section 13c, as applied to the use of drugs by nonprofit hospitals, is responsive to the considered findings of Congress in the National Health Planning and Resources Development Act of 1974, 42 U.S.C. § 300k, 88 Stat. 2226, that

> ". . . (4) Increases in the cost of health care, particularly of hospital stays, have been uncontrollable and inflationary, and there are presently inadequate incentives for the use of appropriate alternative levels of health care, and for the substitution of ambulatory and immediate care for inpatient hospital care.
>
> "(5) Since the health care provider is one of the most important participants in any health care delivery system, health policy must address the legitimate needs and concerns of the provider if it is to achieve meaningful results; and thus, it is imperative that the provider be encouraged to play an active role in developing health policy at all levels."

2. The Section 13c exemption is not limited to supplies that are purchased for use within the walls of the institution.

a. Respondent and amici curiae supporting the

decision of the Court of Appeals contend that Section 13c applies only to purchases of drugs for use in ways that cannot be supplied by retail drugstores (described as uses that are not on "the same functional level", Resp. Br. 33; APhA Br. 4-5, 13; So. Assn. Br. 11-13). Respondent expresses this as a locational test, contending that the exemption applies only to drugs purchased for consumption on hospital premises (Resp. Br. 19, 33-34, 40-46, 63, 65).[7]

Section 13c contains no such restrictions. It is not limited to supplies purchased for use at particular "functional levels" or within the walls of the institution, but extends generally to all purchases for the institution's use. The question is whether the "use" of supplies by a hospital, a church or a school is coextensive with admittedly appropriate functions of the institution. In the case of a hospital, its services to the sick, including pharmaceutical services, are supplied through integrated operations to ambulatory[8] as well as to bedridden patients. It is unrealistic to di-

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[7] In adopting this test, respondent concedes, contrary to the decision of the Court of Appeals (App. 311-312), that some outpatient distribution is the hospital's "own use". Establishing categories of "own use" for churches or schools, which also provide supplies to their members in the course of their activities, would be at least as difficult as doing so for hospitals.

[8] Respondent's assertions that ambulatory patients are not hospital patients, or are not "hospitalized" (Resp. Br. 19, 33, 49, 52, 63), are incorrect; outpatients are registered patients of the hospital, and take-home drugs are dispensed to registered patients before they leave the hospital. APhA refers to both outpatients and departing inpatients as "ambulatory" (APhA Br. 4), whereas none of them are necessarily ambulatory — one knows only that they do not occupy hospital beds (cf Resp. Br. 37, 56).

vide such operations, as the Court of Appeals divided them, between some that are and others that are not the hospital's "own use".[9]

The disputed drug uses are concededly appropriate for nonprofit hospitals, but were excluded from the exemption by the Court of Appeals (App. 310-311) because some of them can be supplied, in whole or in part, through traditional retail channels. But it is precisely in these cases that the exemption has significant operation, and the Court of Appeals, like respondent, misconceived the issue in seeking to limit hospital drug "use" to activities that cannot overlap retail operations.

b. Drugs administered to bed patients are not sold in competition with retail pharmacies. It would be illogical to conclude that Congress passed Section 13c to protect discounts which have no competition impact and do not violate Section 13(a). The purpose of Section 13c was not to "clarify" the Robinson-Patman Act (Resp. Br. 34), but to exempt from the Act discounts granted to institutions operating in the public interest,

[9] Like the Court of Appeals, respondent would construe the statute to equate "use" and "consumption" and distinguish drugs that are "used" from those that are "sold" (Resp. Br. 11, 27, 40-46). However, drugs supplied to inpatients as well as to outpatients are billed to them and are paid for as part of their hospital charges. The hospital does not "consume" any of the drugs that it purchases (see Pet. Br. 21-22), but this does not affect the application of Section 13c. In *Logan Lanes, Inc.* v. *Brunswick Corporation*, (9th Cir. 1967) 378 F.2d 212, cert. den. (1967) 389 U.S. 898 the court held that the exemption applies to all purchases of supplies for the institution's use, whether they are "consumed *or otherwise disposed of*" (378 F.2d at 216; emphasis added).

discounts that could otherwise be illegal. The legislative history shows that the beneficiaries of Section 13c were not granted the exemption because their operations would never impinge on the business of others, but because they perform important public services without the prospect of private gain. An exemption adopted on that basis cannot be limited to uses that by definition do not affect retail markets.

c. "Generalized statements"[10] that antitrust exemptions must be narrowly construed have no application to Section 13c. This is not a case in which an exemption is sought to be implied from a scheme of statutory regulation, e.g., *U.S. v. National Ass'n. Securities Dealers*, (1975) — U.S. —, 95 S. Ct. 2427, 2443, 45 L. Ed. 2d 486, or in which a challenged practice contravenes a limitation in an express statutory exemption that is "as plain as words can make it", *United States v. McKesson & Robbins*, (1956) 351 U.S. 305, 313.

Section 13c expresses a particular social policy that was deemed to be more important than the policy of the Robinson-Patman Act. A narrow construction of a statute that expresses such a social policy is inappropriate. *Logan Lanes, Inc. v. Brunswick Corporation*, supra, (9th Cir. 1967)) 378 F.2d 212, 216, *cert. den.* (1967) 389 U.S. 898. Section 13c, being a corrective statute, should not be narrowly construed. *Galvan* v. *Press*, (1954) 347 U.S. 522, 527; *Rowoldt* v. *Perfetto*, (1957) 355 U.S. 115, 120.

[10] See Report of Committee on Antitrust Exemptions, 33 ABA Antitrust Law Journal 1, 5 (1966).

CONCLUSION

The hospital drug uses that are in controversy are within the Section 13c exemption. The judgment of the Court of Appeals should be reversed, and the district court's summary judgment construing Section 13c should be reinstated.

Respectfully submitted,

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December 1, 1975.

EXHIBIT TO PETITIONERS' REPLY BRIEF

The Court's attention is called to the following inaccuracies and improprieties in respondent's brief:

1. Respondent refers to testimony given before a congressional subcommittee in 1967 as if it were evidence in this record and probative of issues in this case (see footnotes 19, 20, 21, 24, 25, 26, 27, 28, 29, 38, 51, 52, 53, 57, 58, 62, 72, 96).

2. Respondent refers to first cause of action depositions which were taken long after entry of the summary judgment on the second cause of action from which this appeal was taken (see footnotes 8, 9, 13, 19, 24, 25, 27, 28, 29, 34, 35, 37, 38, 39, 40, 51, 54, 109, 110).

3. In citing the testimony of Mr. Earl Kintner before a congressional subcommittee, respondent refers to him as a "former FTC Chairman", see Resp. Br. 59-60, whereas in fact Mr. Kintner testified as counsel for the National Association of Retail Druggists. Hearings, Small Business Problems in the Drug Indusdustry, Subcommittee on Activities of Regulatory Agencies, House of Representatives, 90th Cong., 1st Session at p. 9 (1967).

Respondent's quotation from Mr. Kintner's testimony (p. 59) is also misleading. The question to the witness was:

> "It would be highly unusual, however, for there to be a special purchasing program in behalf of the in-house pharmacy?"

Mr. Kintner's answer, in language not referred to by respondent, commences:

"It would be highly unusual, but * * * ".

Respondent does not suggest the existence, much less the substance of the omitted language.

4. In footnote 38 (p. 17) respondent cites the testimony of hospital witnesses about walk-in sales, but does not refer to testimony of the same witnesses that such sales are limited to cases of immediate need and are negligible in amount (Table 5 at Pet. Br. 35). Similarly, in footnote 40 (p. 18) respondent does not refer to testimony of the same hospital witnesses, that sales of drugs to other hospitals, clinics or drugstores are limited to cases of immediate need and occur rarely (Table 6 at Pet. Br. 36). None of the testimony cited by respondent supports the suggestion in its brief that these kinds of sales are ongoing commercial practices of any nonprofit hospital.

5. The following additional comments on footnotes in respondent's brief are also appropriate:

Footnote 7: The citation is to statements in one of respondent's briefs in the district court (R. 833, found at App. 277).

Footnote 16: The reference is to testimony given before a congressional subcommittee regarding cross-sales, not cross-licensing (R. 133).

Footnotes 26, 31: Respondent contends, based on statements in a House committee report about alleged quantity limitations on sales to retailers, that the

products themselves are not available to retailers. The references do not support the assertion, and there is no evidence in the present record that this happens.

Footnote 32: The reference does not support the statement in the text for which it is cited, i.e., that one of the petitioners gives "extra time for payment" to hospitals that is not given to retailers.

Footnote 39: The references to R. 938 and R. 941 do not support the statement in the text for which they are cited, i.e., that hospitals refill various kinds of prescriptions. The testimony of the hospital witnesses, including the testimony cited by respondent, establishes that with few exceptions the hospitals do not refill take-home prescriptions (see Table 2 at Pet. Br. 32).

Footnote 46: The reference does not support the statement in the text for which it is cited, i.e., that a prescription is written for a drug to be used by one who is "no longer a patient or who was never a patient".

Footnote 49: The references to R. 744, R. 746 and R. 897 do not support the statements in the text for which they are cited, consisting of recitals of the numbers of prescriptions assertedly written by unidentified hospitals over a period of two to four years.

Footnote 58: None of the 13 citations to deposition testimony support the statement in the text for which they are cited, i.e., that hospitals sell drugs at prices below those charged by retailers and lower than retail

drugstores must charge "to economically survive". Charges of such practices made before a congressional subcommittee in 1967 are not probative of facts in this case.

Footnote 62: The certificate referred to in the second paragraph of the footnote was filed in the district court on September 15, 1975, more than two years after entry of the district court's judgment and about a week before respondent filed its brief in this Court. It also shows that 23 new pharmacies opened between January 1, 1971 and May 23, 1975, including 12 in 1971 and 1972, and that the figures cited by respondent are for the entire tri-county area, not Portland alone.

Footnote 70: The references do not support the statement in the text for which they are cited, i.e., that patients at doctors' offices near hospitals purchase drugs at hospital pharmacies. To the extent that the references bear on any issue, they show only that sales to doctors are negligible.

Footnote 99: The references contradict the statement in the text that a Portland hospital refuses to accept indigents.

Footnote 100: The reference to R. 939 is to a list of attorneys contained in the clerk's docket.

Footnote 105: The current (1975) Portland telephone directory does not support the statement in the text for which it is cited, i.e., that drugstore service (including delivery service) is widely available in Portland 24 hours a day. It shows that nearly all

drugstores operate only during regular business hours or in the early evening, and most are closed on weekends or Sundays. Out of 211 listings for the Portland-Burlington-Lake Oswego-Milwaukie area, only six advertise after-hours emergency service.

Footnote 107: There is no evidence that any of these hospitals in the Portland area has a separate pharmacy for outpatients.

Footnote 109: The references do not support the statement in the text for which they are cited, i.e., that drug representatives visit hospitals "to keep close tabs on the drug needs of their hospital customers" and to check their drug stocks.

Appendix footnotes 24 and 25: The article referred to by respondent, published in 1941, does not support the statement in the text for which it is cited, i.e., that drugstores carry more drugs than hospital pharmacies. It states that the average hospital pharmacy stocks 5,000-8,000 items. This is in excess of the average drugstore inventory of about 3,000, as stated by respondent. The same article states that a hospital pharmacy inventory is not limited to the institution's formulary.